ADOLESCENTS AND THE HIV/AIDS EPIDEMIC IN UGANDA

A Briefing Book

by
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for

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Acknowledgements

This briefing book attempts to deal with two intriguing questions. The first is to explain Uganda's relative success in reducing HIV/AIDS sero-prevalence rates from about 30% in 1992 to less than 10% by the year 2000 in some selected sentinel sites. This question was repeatedly raised at the 13th International AIDS Conference held in July 2000 in Durban, South Africa.

The second issue is to do with adolescents. Most of the data on sero-prevalence rates are based on attendees of antenatal clinics (and sometimes STI clinics), hardly a representative group. Just as the improvement of a workforce depends heavily on the quality of new recruits, sexual behavior and trends in HIV/AIDS sero-prevalence rates are influenced to a large extent by the actions of adolescents. The question has always been whether the incoming generations would behave differently from their predecessors. The answer to this question would be cause for either hope or dismay. In Uganda, there is reason for cautious optimism.

Dr. Wilson Kisubi, Pathfinder International, Africa Regional Office, Nairobi, raised the question of Uganda's relative success with me on numerous occasions and inspired this briefing book. I would like to thank Wilson for having posed the question; it is said that asking the right question is about 50% of the research effort.

I would like to recognize the contribution of Stephen K. Kiirya of Makerere University's Institute of Social Research (MISR) to this briefing book, He supplied most of the material on female genital mutilation/cutting (FGM/C) and made a number of editorial suggestions that have improved the quality of the book. I also acknowledge with thanks Ms. Joy Mukaire, Acting Country Representative, and the entire Pathfinder International Uganda Country Office in Kampala for the support they provided in the conduct of this exercise.

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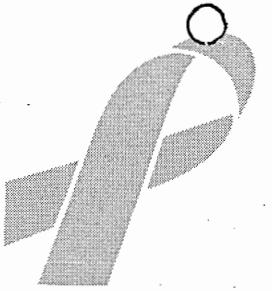
Abbreviations and Acronyms



ACP	AIDS Control Program
AIC	AIDS Information Centre
AIDS	Acquired immune deficiency syndrome
CBO	Community-based organization
HIV	Human immuno-deficiency virus
MACA	Multi-Sectoral Approach to the Control of AIDS
NGO	Non-government organization
PEARL	Program for Enhancing Adolescent Reproductive Life
PLWHAs	Persons living with HIV/AIDS
REACH	Reproductive, Educative and Community Health Program
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
TASO	The AIDS Support Organization
UDHS	Uganda Demographic and Health Survey
UNAIDS	Joint United Nations Program on AIDS
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UWESO	Uganda Women's Effort to Save Orphans
VCT	Voluntary counseling and testing

Introduction

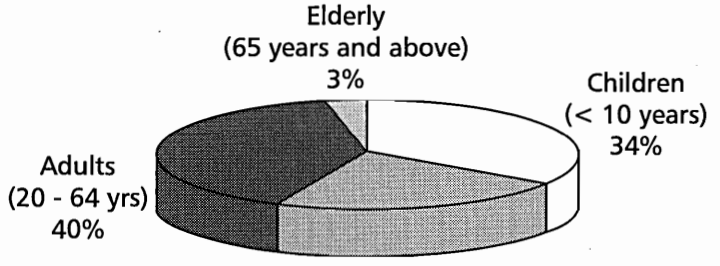
This briefing book is about Adolescents and AIDS in Uganda.

Definitions

AIDS stands for acquired immune deficiency syndrome, and is a condition that results from infection with the human immuno-deficiency virus (HIV). Between being infected with HIV and falling sick with AIDS, one may remain without signs of illness for a long period while infecting others.

Adolescence is the stage of transition from childhood to adulthood. Many hormonal, psychological, and body changes as well as other aspects of maturation take place during this period. Adolescents are individuals aged 10–19; about one in four Ugandans belong to this age group (*see Figure 1).*

Figure 1: Population distribution by major age groups (Source: 1991 Housing and Population Census)



Transmission of HIV/AIDS in Uganda

Heterosexual contact with an infected partner is the main route of transmission and accounts for 75–80% of new infections.

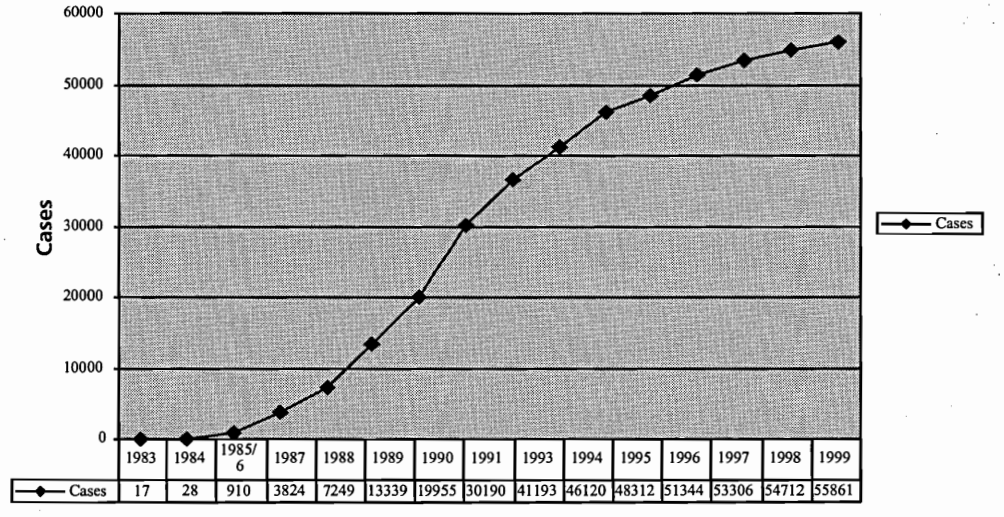
Other routes of transmission include:

- Infected mother-to-child transmission (MTCT) including breast feeding (15–25%). Breastfeeding by an HIV+ mother carries a 15% risk of infection for the infant.
- Use of infected blood/blood products and septic conditions in health facilities (2–4%).
- Sharing non-sterile sharp-piercing instruments with an HIV infected person (< 1%).

HIV/AIDS Cases in Uganda

- The first AIDS cases were observed in Rakai district along the shores of Lake Victoria.
- The disease then spread throughout the country and all districts are now affected.
- By the end of 1996, there were 51,344 reported clinical AIDS cases. This number reached 55,861 by the end of 1999. *Figure 2 shows the cumulative AIDS cases.*
- These are gross underestimates, since an overwhelming majority of cases are not reported.

Figure 2: Cumulative AIDS cases 1983 - 1999
(HIV/STD Surveillance Report, 2000)



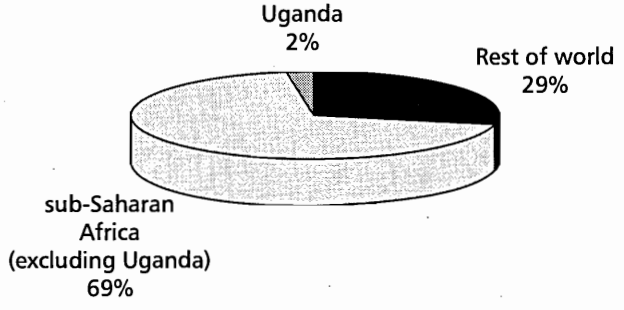
	1983	1984	1985/6	1987	1988	1989	1990	1991	1993	1994	1995	1996	1997	1998	1999
Cases	17	28	910	3824	7249	13339	19955	30190	41193	46120	48312	51344	53306	54712	55861

- By end 1999, the number of HIV infected persons was estimated at 1,438,000, while the cumulative AIDS deaths were 838,000 (*HIV/STD Surveillance Report,* 2000).

- Even though Uganda holds 0.4% (21.2 million) of the world's population, it accounts for 2.4% (820,000 out of 33.6 million) of HIV/ AIDS cases – about six times its proportionate share.

- Also, while sub-Saharan Africa accounts for 9.9% of world population, more than two-thirds (71.4%) of the world's population living with HIV/AIDS reside in this region (UNAIDS, 2000). *Figure 3 displays the distribution of PLWHAs.*

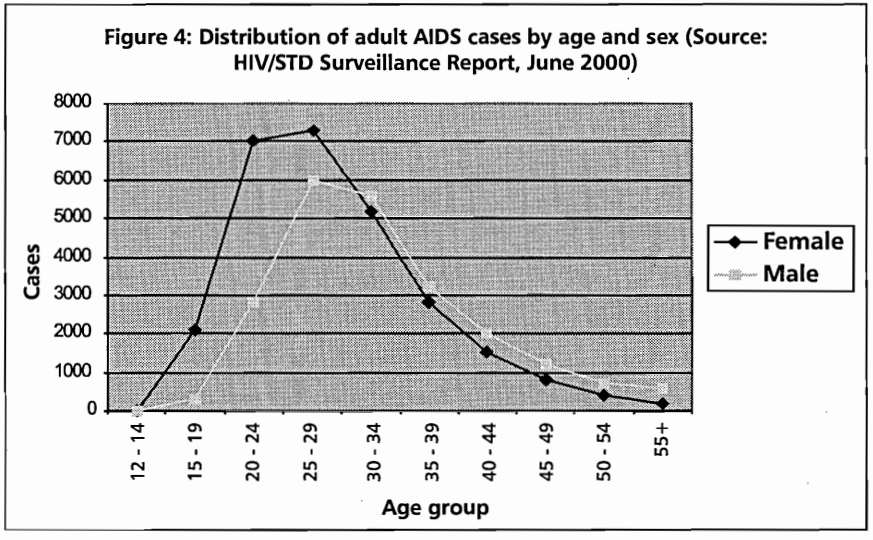
Figure 3: Distribution of persons living with HIV/AIDS
(Source: UNAIDS, June 2000)



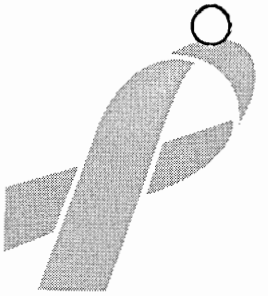
Distribution of AIDS Cases by Age and Sex

Of the 55,861 cases reported to the surveillance unit of the STD/AIDS Control Program by the end of 1999:

- Adults were 51,795 (92.75%) and children aged 12 years and below were 4,066 (7.3%). Some 66% of pediatric cases die before age three.
- The mean age for adult cases was 32.2 years: 34.6 years for males and 31.3 for females.
- While the male to female ratio is approximately 1:1.2, it varies considerably across age groups.
- HIV infection cases begin to increase in the age group 15–19 and peak in the age group 25–30.
- Girls aged 15–19 are two to six times more likely to be infected than boys that age.



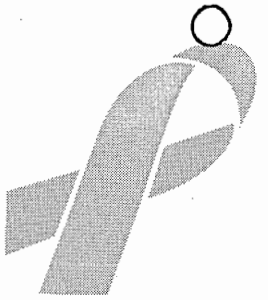
Women and AIDS



Females experience higher prevalence rates of HIV/AIDS up to the age of 35 years; past that age men show higher rates. This pattern arises because:

- Girls engage in sex at an earlier age (15.6 years) than boys (17.6 years).
- More girls (84%) than boys (26%) initiate sex with older partners.
- Girls also enter marriage much earlier (17 years) than boys (19 years).
- A majority of girls (62%) encounter pregnancy by age 19.
- A relatively large percentage (43%) of the females who carry the first pregnancy are teenagers.
- There is a long-standing pattern of older men engaging in sex with adolescents, particularly girls, in an attempt to avoid contact with HIV.
- A study conducted among secondary school students found that 31% of the girls and 15% of the boys who are sexually active had ever had nonconsensual sex contact, usually with their teachers.

AIDS and Education



HIV-related infection is taking its toll on education in the following ways:

- Eroding the supply of teachers.
- Diverting funds that should have been spent on education to patients' care.
- Increasing the proportion of AIDS orphans, who are often forced to drop out of school and assume roles of an adult at an early age.
- Disproportionately affecting girls, who may be ailing with the disease or called upon to take care of family members who are ill. Either way, their educational prospects are eroded.

Phases of the AIDS Epidemic

The HIV/AIDS epidemic can be traced in three phases. These vary according to groups most infected and trends in prevalence rates.

Phase One

- Limited to high risk groups, which include commercial sex workers and their clients, as well as mobile individuals, truck drivers, the military, and young people with multiple partners.

- Associated with large urban areas.

- Grows rapidly; sero-prevalence rates may double in less than five years.

Phase Two

- Spreads to the business community and smaller urban areas. The overall sero-prevalence rates increase further.

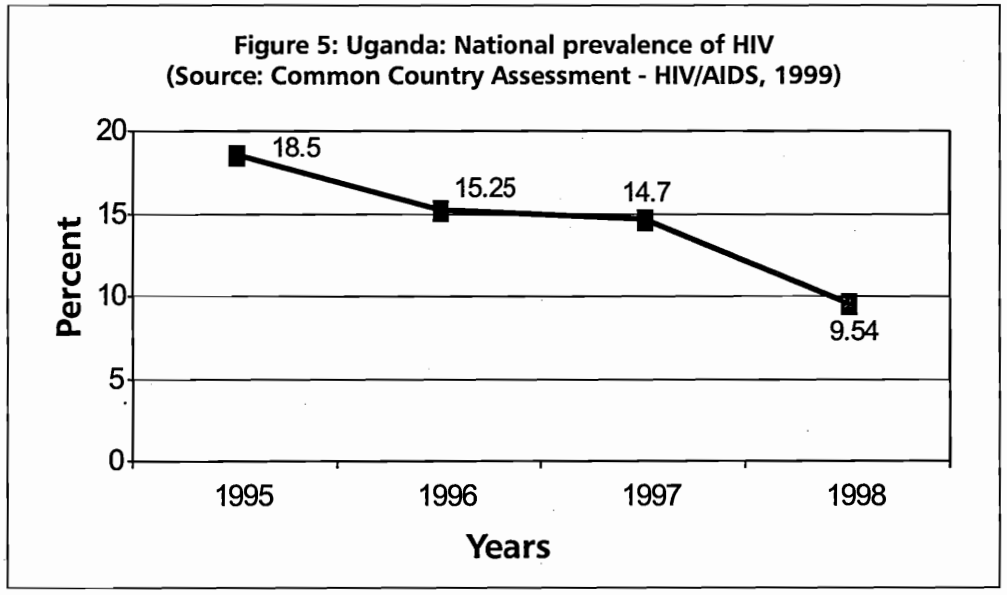
Phase Three

- Spreads to rural areas, resulting in high sero-prevalence rates for the general population.

The Fourth Phase

Uganda has added a fourth phase – ***decline in prevalence.***

- HIV infection rates at Uganda's major sentinel surveillance sites show a declining trend beginning in 1992. ***The greatest decline is occurring among young people.***
- This marks the first time in sub-Saharan Africa that HIV infection rates have gone ***down***.

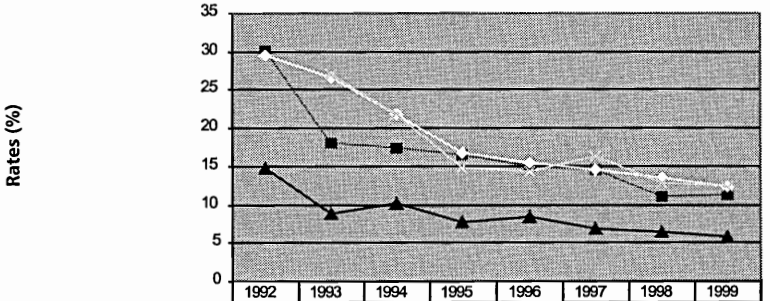


- Decline in HIV infection rates is particularly observed among antenatal clinic attendees in two hospitals from 13.4% and 14.2% in 1998 to 12.4 and 10.5%, respectively, in 1999 (*Figure 5 shows HIV infection trends since 1992*).

- The decline is also observed in Lacor Hospital (Gulu) in Northern Uganda, from 27.1% in 1993 to 12.4% in 1999.

- Similarly, data from the AIDS Information Centre indicate decline in prevalence among 15–24-year-olds seeking voluntary counseling from 11% among males and 29% in females in 1992 to 2.5% and 2.1%, respectively, in 1999. *Figure 6 shows HIV rates among first-time testers aged 15–24 at AIC.*

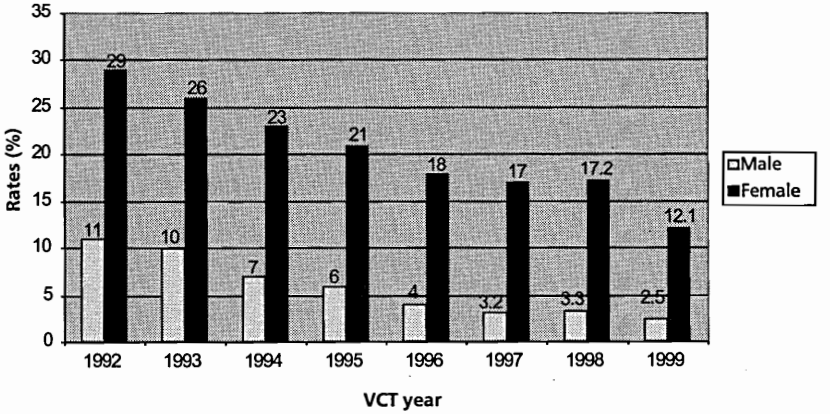
Figure 6: HIV infection rates among ANC attendees 1992 - 1999
(Source: HIV/STD surveillance report, 2000 June)



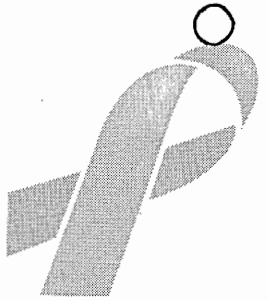
	1992	1993	1994	1995	1996	1997	1998	1999
Nsambya (Central)	29.5	26.6	21.8	16.8	15.4	14.6	13.4	12.3
Mbarara (Western)	30.2	18.1	17.3	16.6	15	14.5	10.9	11.3
Mbale (Eastern)	14.8	8.7	10.2	7.8	8.4	6.9	6.3	5.7
Gulu/Lacor (Northern)		27.1	21.9	14.7	14.3	16.3	12.8	12.3

Sentinel site and year

Figure 7: HIV rates among first-time testers aged 15 - 24
(Source: AIDS Information Centre)



The Decline among Adolescents



The main reasons for the decline in HIV prevalence among adolescents:

- Promotion of IEC for behavior change, which has resulted in an increase in AIDS knowledge from 72% in 1995 to 87% in 1998 in Lira.
- Increase in condom use from 34% in 1995 to 67% in 1998 (Jinja).
- The reduction in the proportion of individuals reporting sex with non-regular partners, from 11.4% in 1995 to 6.4% in 1998 (Soroti) (STD/HIV Surveillance Report (2000).
- Increase in age at first sex.

Factors that Negatively Affect Adolescents in Uganda

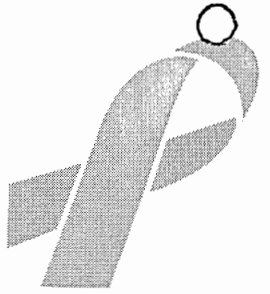
Despite the decline, adolescents are still at risk for a variety of reasons:

- Abuse of power by older or wealthier individuals
- Scarcity of HIV counseling and testing facilities and of condoms
- Even when available, services that are usually not adolescent friendly (i.e., youth are not expected as clients)
- Poverty that leads to prostitution
- Drug and alcohol abuse
- Domestic violence and rape
- Inadequate care and support for those infected and affected
- Military conflict and labor migration, which split up families (UNAIDS, 2000)

These factors operate through the following proximate determinants:

- Age at sexual debut
- Number of sex partners
- Age of sex partner
- Sexual curiosity and experimentation

The PEARL Study



Data from the PEARL study (1999) indicate that:

- Both boys and girls are involved in sexual intercourse at an early age.
- The median age at sexual debut ranged from a low of 14.6 years for Mukono district to a high of 16.8 in the case of Soroti for males.
- For females the corresponding range was 15 years in case of Mubende to 16.8 in the case of Soroti.
- The median number of sex partners for adolescents within the six months preceding the survey is 2.
- Adolescents tend to change sex partners frequently out of curiosity and adventure. In addition, most of them are unmarried and highly mobile – they change residence to look for jobs and this leads to separation from their sex partners and acquiring new ones.
- More than 13% stated that they had had sexual contact with a non-regular partner in the 12 months preceding the survey.

The PEARL Study - 2

- Girls are more likely to be linked with older sex partners. The UDHS (1995) revealed that girls aged 15–19 are linked to husbands who are older by 6–8 years.
- Older men are a risk factor in the transmission of HIV and other STDs since they would have been exposed to the risk of infection for a much longer period.
- The desire to experiment, exchange of sex for rewards (gifts), and coercion are the main circumstances surrounding the first time boys and girls engage in sex.
- More girls than boys reported that they had engaged in sex for rewards (gifts). Those who had sex in exchange for gifts are older, and were more likely to be infected due to the higher age of their partners and longer sexual experience.
- Meanwhile, sizeable proportions of female adolescents reported being coerced into sex in the districts of Bushenyi (8%), Iganga (18.8%), Kabarole (18%), Mubende (10.5%), Mukono (20.2%), Soroti (6.3%) and Tororo (6.1%).
- More specifically, early sex and forced sex were closely associated.

Factors Underlying Adolescent Sexuality

The PEARL study (1999) found that several factors underlie the unfavorable indicators of the adolescents sexual and reproductive life.

- Early sexual relations are clearly associated with leaving school early or never going to school. Iganga, the district with the highest fertility rate, recorded the highest proportion of ever married female adolescents (40.6%) and lowest proportion who ever attended school.

- Early sexual activity is also associated with living conditions. In Lawiye Adul, Gulu, boys of 13–14 years of age leave the parental home and are given their own separate homestead and there is little control over their sexual behavior thereafter.

- Since virginity at marriage is highly prized, it is in the financial interests of families to marry off their daughters early.

- Data from the Uganda Demographic and Health Survey (1995) showed that the mean age at marriage for girls was 17 years. By age of 20 years nearly all girls have been married at least once, and on average, their husbands are 6–8 years older.

More Factors Underlying Adolescent Sexuality

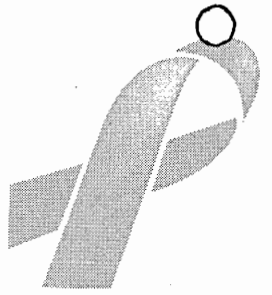
- Rites of passage such as circumcision are performed during adolescence. This tends to confer on boys the status of being a man and the expectation is to behave like one including having sexual relations.

- Other cultural occasions held in the night such as last funeral rites and ceremonies of twins provide the avenues for adolescents to engage in sex.

- In the central and eastern region labia elongation is performed on girls during puberty. This practice is aimed at giving additional sexual pleasure to one's future husband and is an overt indication that the girl is ready for sex.

- Wife inheritance is another cultural practice that predisposes adolescent girls to HIV/AIDS infection. It is the practice for a man who loses a wife to acquire a young unmarried girl from the same clan as the late wife. This is also the case when an older woman who has failed to bear children brings in her niece and shares her husband with her. However, these practices are declining because of the AIDS epidemic.

The Role of Female Circumcision



- Female circumcision is another cultural practice associated with HIV transmission. According to UNFPA (2000), a few communities in Uganda practice female genital cutting/mutilation (FGC/M). These include the Sabiny, Pokot, Bok Tipeth, and those of Nandhi, Somali, and Sudanese descent.

- Records from the Reproductive, Educative, and Community Health (REACH) Program in Kapchorwa district show that 971 girls underwent FGC/M in 1990, 903 in 1992, 854 in 1994, and 544 in 1996.

- The eligible age for FGC is 15 years onwards, although some undergo this ritual earlier for prestige. This practice also confers the status of womanhood on teenage girls, including sex, which thereby exposes them to the risk of HIV infection through early sex.

Uganda's Response to HIV/AIDS since 1982

The national response to the epidemic has been characterized by:

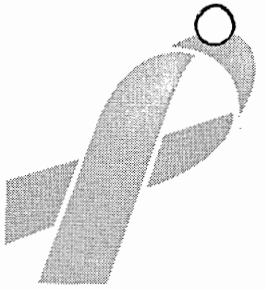
- A policy of openness, which has benefited from support and commitment from the highest level of Government.
- Government's recognition that HIV/AIDS poses a real and serious threat to the socioeconomic life and development of the country.
- Formation of the Uganda AIDS Commission (UAC) and its Secretariat in 1992, which was specifically charged with the responsibility of formulation and development of the national multi-sectoral response.
- Government recognition that the epidemic affected various aspects of individual, family, community, and national life.
- Formation of a number of NGOs/CBOs to deal with specific aspects of the disease; at present there are an 1,300 such groups (Inventory of AIDS NGOs, 1997).

Uganda's HIV/AIDS Related NGOs/CBOs

Among the NGOs and CBOs are:

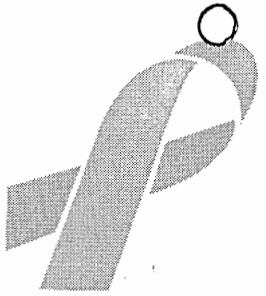
- The AIDS Information Center, which focuses on voluntary counseling and testing (VCT).
- The AIDS Support Organization (TASO), which provides care and support to PLWHAs.
- Uganda Women's Effort to Save Orphans (UWESO), which provides financial and material assistance to orphans.
- Orphanages in various parts of the country.

AIDS Policy Guidelines



These revolve around the following principles:

- Civic leaders at all levels should deal with local issues concerning HIV/AIDS.
- There must be specific AIDS control programs within the security sector to prevent the undermining of national security.
- Control efforts should be directed to all parts of the country and no people should be denied support because of their geographical location or any other factor.
- Corruption, abuse of power, stigmatization, and discrimination in employment and access to other social amenities, as well as exploitation of PLWHAs and their affected families, should be eliminated when dealing with HIV/AIDS.
- HIV/AIDS policies should reflect national aspirations, should be in line with the interests of the people of Uganda, and should take into consideration the existing policies in other parts of the world.



Achievements

General Achievements

Most of the achievements made so far in the fight against HIV/AIDS are attributed to the policy of openness adopted by the Government of Uganda (MACA & NOP, 1994).

> *"African Ministers were stunned and scandalized by my speech, which pointed out that HIV/AIDS is a big problem in Uganda and Africa as a whole. They said we had brought shame on Africa, tourism would suffer, and the good image of Uganda would be lost ... But we have said to hell with tourism and resolved to deal with the problem openly."*
>
> - Excerpt from the interview with Rukahana Rugunda Minister for Presidency by Smith of the *Independent* newspaper of London during the 13th International AIDS Conference in Durban, South Africa, July 2000.

This led to the following major developments:

- Creation of UAC to oversee the implementation of the Mult-sectoral Approach to the Control of AIDS (MACA).

- Creation of AIDS control programs (ACPs) in government ministries to deal with the AIDS-related issues that are in line with their respective mandates.

- Fronting the policy of openness to HIV/AIDS at all levels – meaning that the epidemic became a subject for discussion at a variety of forums: within families, civic meetings, churches, and at the district and national levels. For example, in a recent pass out of army officer cadets the president told them that HIV/AIDS was the number one enemy they faced (*The New Vision*, August 26, 2000).

Government placed HIV/AIDS high on the development agenda for Uganda:

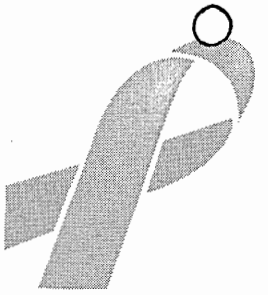
- In the Poverty Eradication Action Plan (PEAP), HIV/AIDS is accorded the same status as other priority development areas, which include agricultural research and extension, primary health care, basic education, rural water supply, and maintenance of feeder roads.

- As a result, some of the funds released through debt relief from the World Bank and other donors are earmarked for fighting the epidemic.

The Resources Necessary Are Staggering

It is estimated that between 1994 and 1996, US$117 million was spent on HIV/AIDS activities, and could have increased to over US$130 million between 1997 and 2000 (Kayita and Kyakulaga, 1997). Estimates of the new national strategic framework for HIV/AIDS activities for the period 2000/1–2005/6 indicate that the cost of interventions will be equivalent to the entire annual health budget of US$130 million, excluding cost of anti-retroviral therapy and drugs for treatment of opportunistic infections including tuberculosis.

Specific Achievements



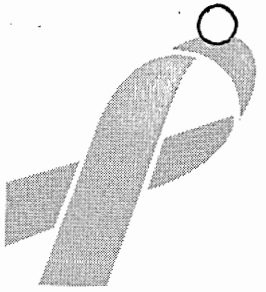
HIV/AIDS prevention and control efforts have begun to pay off and ***the prevalence rates have declined since 1992.*** The following factors are believed to be responsible for the decline:

- High knowledge of HIV/AIDS transmission mode, risk factors, symptoms and what to do to avoid infection: more than 90% of the adult population would give correct answers.

- Identification of infected individuals on the basis of symptoms, which engenders prudent behavior within small communities.

- Change in sexual behavior, including postponement of age at first sexual contact reduction in number of partners. The change has been pronounced among adolescents.

More Specific Achievements

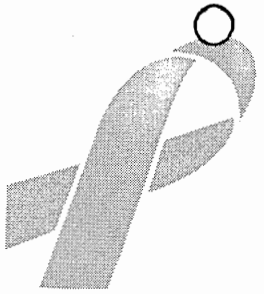


- Decline in the incidence of wife inheritance in some communities.

- Increase in condom use. Again, the change is pronounced among adolescents. Studies indicate that only 4.9% of respondents aged 15–19 had ever used a condom (UDHS, 1995), but this percentage had risen to 29.4% by 1999 in the remote district of Kibaale (PEARL, 2000).

- Decline in the prevalence of STDs, whose presence raises the risk of HIV transmission. In Rakai district, there was a reduction in STD rates throughout the district because of STD management interventions. The prevalence of syphilis and trichomoniasis specifically declined from 10% and 24.3% in 1994/5 to 6.3% and 11.6%, respectively, in 1999 (Rakai District, 2000).

Specific Interventions that Worked



It is difficult to pinpoint the activities that led to a greater degree of awareness and knowledge about HIV/AIDS that changed people's attitudes towards the disease. However, the following interventions are believed to have contributed to this success:

- Government leadership in all AIDS efforts through successive reviews and revisions of the National Operational Plan.

- The existence of a national HIV/AIDS framework, agreed upon by a wide spectrum of stakeholders, which has simplified the process of designing projects and accessing funds by both government and non-government organizations.

- The existence of a large number of stakeholders focusing on HIV/AIDS, who have specific areas of specialization and target groups. For example, AIC specializes in VCT services while TASO offers care and psychosocial support for those infected with HIV. Traditional healers offer a holistic service that combines religious, cultural, and medical aspects.

- Intensive multi-media HIV/AIDS campaigns, which have included posters, pamphlets, newspaper articles, films, and radio and TV spots.

Government Commitment at the Highest Level

"AIDS has killed more of our people than Kony and Kabila put together. So your biggest enemy is not Kony but AIDS and you must guard against it. After all we checked you and found you to be free from AIDS."

- Excerpt from President Museveni's speech during the passing out of Army Officer Cadets in August 2000 at the Gaddafi Military Training School in Jinja, Uganda).
(Kony is the Commander of the Lord's Resistance Army that has fought the NRM Government since 1988, while Kabila is the President of the Democratic Republic of Congo where the Uganda People's Defense Forces backed rebels to oust him.)

More Interventions

- Existence of population-specific HIV/AIDS interventions such as the UNICEF-supported "Safeguard the Youth from AIDS (SYFA)" program. As part of this program, *New Vision* newspaper publishes "Straight Talk" in various languages targeting children and youth.

- A multi-pronged assault on HIV/AIDS: from the moral/ethical standpoint by the religious organizations; medical perspective by health service providers, and socioeconomic ramifications by civic and political leaders.

- The general IEC message summed up in **A**bstinence (postpone or suspend sexual activity until you have a regular partner), **B**eing faithful to one partner, and consistent **C**ondom use before marriage was relevant to a wide range of situations.

- The decentralization policy embarked on in 1997, whereby certain roles and responsibilities have been ceded to lower levels of government. This has led to the generation of HIV/AIDS information in the context of local governments (districts and sub-counties) and smaller administrative units (parish units). It is evident that such information assists local governments to visualize the AIDS problem better and pass relevant by-laws.

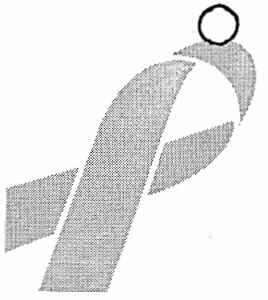
Outstanding Gaps

Even though there has been a significant decline in HIV/AIDS sero-prevalence since 1992, a lot remains to be done:

- The current prevalence rates, hovering around 10%, are unacceptably high given the high fatality from the disease.
- There are pockets in the country where in the recent past the prevalence is rising rather than declining. Data from South Rwenzori Diocese (Kasese district) show such a trend for January–June 2000, i.e., from about 9% to 14%. The disparities in sero-prevalence between regions is due to limited diffusion of HIV/AIDS knowledge to all parts of the country.

> A recent exploratory visit found that many sub-county chiefs had never seen a condom leave alone using one. *In Uganda, there are about 1,000 sub-counties and a sub-county chief is in charge of 20,000–22,000 individuals, representing about 4,000 households (District Response Initiative, 2000).*

More Gaps



- Voluntary counseling and testing (VCT) services, which give knowledge of one's sero-status and lead to correct behavior, are concentrated in a few districts; a number of districts do not have even one such center.

- Condom distribution points are in urban areas, leaving a large sector of the rural population under-served. In addition, rural residents are less likely to afford condoms even if they are within easy access.

- Living conditions among internally displaced persons and refugees militate against the control of HIV/AIDS. There is little privacy, family life and norms have been disrupted, and individuals tend to have sex whenever they can. Rape is common.

The Way Forward

Since neither vaccine nor cure has been found for HIV/AIDS, it is necessary to do the following:

- Vigorously pursue strategies that emphasize changing sex behavior. Intensification of these approaches could yield further declines in HIV/AIDS prevalence.
- Increase the level of knowledge about HIV/AIDS throughout the country for all age groups and socioeconomic groups.
- Provide appropriate HIV/AIDS services and support including expansion of the network of VCT services so as to reach a higher proportion of the population.
- Establish friendly condom distribution points especially in rural areas.
- Respond to the needs of internally displaced persons by providing them with reproductive health services including VCT and condom distribution.
- Provide adolescents with life planning skills so as to build their confidence to change behavior, and enable them translate knowledge into action to avoid HIV infection.
- Provide information that motivates adolescents to make responsible life decisions.
- Incorporate elements of adolescent empowerment and referral into the whole network of STI services, including talent development and self-esteem building of adolescents.

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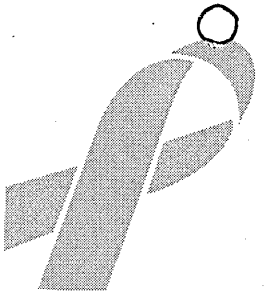

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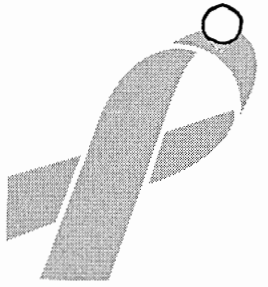

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